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Issue Date: 12 December 2002

In the Matter of
Earl Evans
Claimant

v.

Dixie Coal Co.,
Employer

and

Director, Office of Workers' Compensation Programs
Party-in-Interest

Case No. 2001-BLA-00269

DECISION AND ORDER
AWARDING BENEFITS
Jurisdiction and Claim History

This case comes on a request for hearing filed by the Claimant, Earl Evans, on September 6, 2000 pursuant to the provisions of Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. §§901 *et seq.* (the Act.). A hearing was held on August 20, 2002 in Middlesboro, Kentucky. The Claimant was represented by Joseph Wolfe, Esquire, Wolfe and Farmer, Norton, Virginia. The Employer was represented by Debra Fulton, Esquire, Frantz, McConnell and Seymour, Knoxville, Tennessee. Thirty five (35) Director's exhibits (Hereinafter "DX" 1 to 35) were admitted into evidence. Two (2) Claimant's exhibits ("CX" 1 and CX 2) were admitted. Eight (8) Employer exhibits ("EX" 1-8) were admitted. Employer objected to the admission of CX 1 and 2, on the basis that the exhibits were not proffered within 20 days prior to hearing, as required by my pre-hearing Order and by 20 CFR § 725.456.[1] However, I left the record open for thirty days post hearing, to permit Employer the opportunity to rebut evidence contained in CX 1 and CX 2. On or about September 16, 2002, Employer submitted a two page report from Dr. Gregory Fino, dated September 12, 2002. This document is marked as EX 9 and is admitted into evidence. Although I left the record open to receive briefs from the parties, none were proffered.

This is the fourth time that Mr. Evans has filed an application for benefits; prior claims were filed January 1, 1978, October 26, 1992 and November 24, 1997, and are administratively final. The Claimant attempted to file a modification request on the 1997 application on April 2, 1999 but was late, as the law requires that it must be filed within one year from the date of the last payment of benefits or at any time before one year after the denial of a claim, as the last activity occurred February 11, 1998 (DX 33-10). 20 C.F.R. § 725.310(a). The Claimant did not request a hearing on this issue; rather he filed a new application on April 17, 1999 (DX 1).

[1] (2) Subject to the limitations in paragraph (b)(1) of this section, any other documentary material, including medical reports, which was not submitted to the district director, may be received in evidence subject to the objection of any party, if such evidence is sent to all other parties at least 20 days before a hearing is held in connection with the claim. However, an administrative law judge may keep the record open to allow the submission of post-hearing evidence to respond to evidence submitted in violation of the 20 day rule. 20 C.F.R. §§ 725.456(b)(2); see ***Bethlehem Mines Corp. v. Henderson***, 939 F.2d 143 (4th Cir. 1991).

Burden of Proof

"Burden of proof," as used in the this setting and under the Administrative Procedure Act[2] is that "[e]xcept as otherwise provided by statute, the proponent of a rule or order has the burden of proof". "Burden of proof" means burden of persuasion, not merely burden of production. 5 U.S.C.A. § 556(d)[3]. The drafters of the APA used the term "burden of proof" to mean the burden of persuasion. ***Director, OWCP, Department of Labor v. Greenwich Collieries*** [Ondecko], 512 U.S. 267, 114 S.Ct. 2251 (1994).[4]

The claimant bears the burden of establishing the following elements by a preponderance of the evidence: (1) the miner suffers from pneumoconiosis, (2) the pneumoconiosis arose out of coal mine employment, (3) the miner is totally disabled, and (4) the miner's total disability is caused by pneumoconiosis. 30 U.S.C. §901; 20 C.F.R. §§718.3, 718.202, 718.203, 718.204. ***Gee v. W.G. Moore and Sons***, 9 B.L.R. 1-4 (1986)(*en banc)*; ***Baumgartner v. Director, OWCP***, 9 B.L.R. 1-65 (1986)(*en banc)*.

A claimant has the general burden of establishing entitlement *and* the initial burden of going forward with the evidence. The obligation is to persuade the trier of fact of the truth of a proposition, not simply the burden of production, the obligation to come forward with evidence to support a claim.[5] Therefore, the claimant cannot rely on the Director to gather evidence.[6] A claimant, bears the risk of non-persuasion if the evidence is found insufficient to establish a crucial element. ***Oggero v. Director, OWCP***, 7 BLR 1-860 (1985). Failure to establish any one of these elements precludes entitlement. ***Anderson v. Valley Camp of Utah, Inc***., 12 BLR 1-111, 1-112 (1989); ***Trent v. Director, OWCP***, 11 BLR 1-26, 1-27 (1987).

Issues

The issues are as follows:

1. Whether the miner had pneumoconiosis as defined by the Act and the Regulations.
2. If so, whether the miner's pneumoconiosis arose out of his coal mine employment.
3. If the Miner is totally disabled.
4. And if so, whether the miner's disability was due to pneumoconiosis.
5. And if so, what is the date of onset?

Gee and; ***Baumgartner,*** *supra.* Secondary issues involve how long the Claimant engaged in coal mine employment and how long he had smoked tobacco products and the relationship, if any to the alleged total disability.

Stipulations

The parties agree that this claim was timely filed, the Claimant was a "miner" under the Act, the identity of the Employer as "Responsible Operator" that he has one dependent for augmentation purposes (see DX 34), and that he spent in excess of ten (10) years in coal mine employment (Tr 32). After a review of the evidence, I accept the stipulations are substantiated by the record.

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[2] 33 U.S.C. § 919(d) ("[N]otwithstanding any other provisions of this chapter, any hearing held under this chapter shall be conducted in accordance with [the APA]"); 5 U.S.C. § 554(c)(2). Longshore and Harbor Workers' Compensation Act ("LHWCA"), 33 U.S.C. §§ 901-950, is incorporated by reference into Part C of the Black Lung Act pursuant to 30 U.S.C. §§ 932(a).

[3] The Tenth and Eleventh Circuits held that the burden of persuasion is greater than the burden of production, ***Alabama By-Products Corp. v. Killingsworth***, 733 F.2d 1511, 6 BLR 2-59 (11th Cir. 1984); ***Kaiser Steel Corp. v. Director, OWCP*** [*Sainz*], 748 F.2d 1426, 7 BLR 2-84 (10th Cir. 1984). These cases arose in the context where an interim presumption is triggered, and the burden of proof shifted from a claimant to an employer/carrier.

[4] Also known as the risk of nonpersuasion, see 9 J. Wigmore, ***Evidence*** § 2486 (J. Chadbourn rev.1981).

[5] ***Id***, *also see* ***White v. Director, OWCP***, 6 BLR 1-368 (1983)

[6] ***Id***.

Duplicate Claim

Any time within one year of a denial or award of benefits, any party to the proceeding may request a reconsideration based on a change in condition or a mistake of fact made during the determination of the claim; see 20 C.F.R. §§725.310. However, after the expiration of one year, the submission of additional material or another claim is considered a duplicate claim which will be denied on the basis of the prior denial unless the claimant demonstrates a material change in conditions under the provisions of 20 C.F.R. §§725.309 as interpreted by the Benefits Review Board (?Board?) and Federal Courts of Appeals. Under this regulatory provision, according to the Court of Appeals for the Sixth Circuit in ***Sharondale Corporation v. Ross***, 42 F.3d 993, 997-998 (6th Circuit 1994):

> [T]o assess whether a material change is established, the ALJ must consider all of the new evidence, favorable and unfavorable, and determine whether the miner has proven at least one of the elements of entitlement previously adjudicated against him. If the miner establishes the existence of that element, he has demonstrated, as a matter of law, a material change. Then, the ALJ must consider whether all of the record evidence, including that submitted with the previous claims, supports a finding of entitlement to benefits.

The Court of Appeals for the Fourth Circuit has followed the ***Sharondale*** approach. ***Lisa Lee Mines v. Director, OWCP***, 57 F.3d 402 (1995), aff'd 86 F.3d 1358 (4th Circuit 1996)(en banc).20 I interpret the Sharondale approach to mean that the relevant inquiry in a material change case is whether evidence developed since the prior adjudication would now support a finding of an element of entitlement. The court in ***Peabody Coal Company v. Spese***, 117 F.3d 1001, 1008 (7th Circuit 1997) put the concept in clearer terms:

> The key point is that the claimant cannot simply bring in new evidence that addresses his condition at the time of the earlier denial. His theory of recovery on the new claim must be consistent with the assumption that the original denial was correct. To prevail on the new claim, therefore, the miner must show that something capable of making a difference has changed since the record closed on the first application.

Evidence

The claimant testified that he was sixty-six (66) years of age, but he would turn sixty-seven in October (Tr 13). The application shows that Mr. Evans was born October 18, 1938 (DX 1). If this is correct, Mr. Evans is sixty-four. His wife is Martha Evans; and he testified that he has no other dependents (Tr 14). However, his application lists a grandchild, Thomas Christian Evans, born December 18, 1987, as a dependent (DX 1).Mr. Evans alleged that he had a marginal education and can not read, although he knows how to sign his name (Tr 18).

Mr. Evans testified that he had worked about twenty (20) years in the mines; eight (8) in underground mining and the remainder in strip mining (Tr 14-15). He last worked for Dixie Pine Coal Company and left work in 1983 or 1984 (Tr 15). Later he stated that he left coal mine employment in 1980 (Id.). The Dixie Pine job was at a strip mine (Tr 19). Work at Harris Branch Coal Company and John Van Huss involved underground mine work (Id.). He testified that he operated a jackhammer, loaded the shot holes, cleaned coal, did laboring jobs, and sometimes oiled a dragline (Tr 15-16)

The Claimant testified that his current treating physician is Dr. Kubir [actually Kabir], who has been treating him for about five years.(Tr 17). He testified that he has received Social Security Disability benefits for a breathing impairment since 1984 or 1985 (Tr 20-21). He also had arthritis that affects his hands and legs (Tr 21).

The Claimant admitted that he has been a cigarette smoker most of his life and that he still smokes a pipe, but alleged that he had not smoked cigarettes in the past fifteen (15) years (Id.). He has smoked a pipe intermittently over the past twenty (20) years (Id.). He denied telling anyone that he didn't smoke (Tr 22).

According to the Claimant, he can not return to mine work because he has no "wind", and alleges, "I can't breathe." (Tr 18). Although he did not fully describe his symptoms on the record at hearing, the application shows that he alleges shortness of breath and "smothering" which

requires several types of daily medical treatment. He alleges that he has resulting pains in the arms and legs, and can not walk very far and can not lift at all. He alleges frequent cough and spasm, caused by exertion. DX 1. Medical histories furnished by the claimant after he filed his latest application also relate the same or similar complaints (DX 4 and DX 7). However, medical histories provide that the Claimant has had a mild myocardial infarction and he also had traumatic injuries including a clavicle fracture and rib fracture (DX 33-14). He complained to doctors that he has low back pain (Id.).

The following is a summary of the medical evidence of record:

X-RAY REPORTS				
EXHIBIT NO.	**DATE**	**DATE OF REREADING**	**PHYSICIAN AND QUALIFICATIONS**	**DIAGNOSIS AND COMMENTS**
DX 31-23	02/10/69		Seramons	Granulomatous changes
DX 31-15	09/09/70	09/10/70	Dukes	Normal chest
DX 31-12	08/01/79	09/12/79	Cole	1/0
DX 14	08/01/79	03/17/98	Shipley/Bd & B	0/0
DX 31-13	08/01/79	12/22/84	Elmer/Bd & B	0/0
DX 14	08/01/79	03/10/98	Wiot/Bd & B	0/0
DX 31-14 & DX 31-16	08/01/79		Cohen/Bd	Normal chest, 0/0
DX 14	08/01/79	03/30/98	Spitz/Bd & B	0/0
DX 23	08/01/79	12/09/99	Dahhan/B	0/0
DX 31-23	08/28/79		Pongdee	Negative chest
DX 31-28	08/28/79	06/14/81	Pendergrass/Bd & B	0/0
DX 31-26	08/01/79	05/19/81	Combs/Bd & B	0/0
DX 31-26	02/21/80	03/31/80	Combs/Bd & B	0/0
DX 31-21	02/21/80		Rogers	0/1
DX 14	02/19/93	03/17/98	Shipley/Bd & B	0/0
DX 32-9	02/19/93	03/20/93	Sargent/Bd & B	0/0
DX 14	02/19/93	03/10/98	Wiot/Bd & B	0/0
DX 33-17	02/19/93	05/04/93	Pendergrass/Bd & B	0/1, nonspecific interstitial markings, lower lung
DX 32-8	02/19/93		Hudson/Field	1/0
DX 14	02/19/93	03/30/98	Spitz/Bd & B	0/0
DX 23	02/19/93	12/09/99	Dahhan/B	0/0
DX 23	01/21/98	12/09/99	Dahhan/B	0/0

X-RAY REPORTS				
EXHIBIT NO.	**DATE**	**DATE OF REREADING**	**PHYSICIAN AND QUALIFICATIONS**	**DIAGNOSIS AND COMMENTS**
DX 33-7	01/21/98		Hudson/Field	1/0
DX 33-8	01/21/98	01/30/98	Sargent/Bd & B	0/0, smoking history? Emphysema
DX 14	01/21/98	03/10/98	Wiot/Bd & B	0/0
DX 14	01/21/98	03/30/98	Spitz/Bd & B	0/0
DX 14	01/21/98	03/17/98	Shipley/Bd & B	0/0
DX 26	02/05/99		Mullens	Pulmonary hyperinflation consistent with obstructive pulmonary disease
EX 1	02/05/99	03/29/02	Spitz/Bd & B	0/0
EX 2	02/05/99	02/22/02	Perme/Bd & B	0/0
EX 3	02/05/99	01/15/02	Wiot/Bd & B	0/0
DX 33-14	02/05/99		Robinette	1/0
DX 12	05/26/99	06/07/99	Sargent/Bd & B	0/0
DX 11	05/26/99	05/27/99	Cohen/Bd	0/0
DX 23	05/26/99	12/09/99	Dahhan/B	0/0
DX 23	12/03/99		Dahhan/B	0/0
DX 25	12/03/99	01/14/00	Wiot/Bd & B	0/0
DX 12	12/03/99	01/19/00	Perme/Bd & B	0/0
	12/03/99	03/05/00	Spitz/Bd & B	0/0
EX 1	02/14/01	03/29/02	Spitz/Bd & B	0/0
EX 4	02/14/01	12/27/01	Wiot/Bd & B	0/0
CX 1	02/14/01	02/15/01	Patel	1/1
EX 5	11/25/85 6/19/87 03/28/90 07/22/92 09/07/92 09/11/92 03/17/93 08/29/93 06/02/94 03/30/97 11/18/99	0308/91	Wiot/Bd & B	0/0

X-RAY REPORTS				
EXHIBIT NO.	**DATE**	**DATE OF REREADING**	**PHYSICIAN AND QUALIFICATIONS**	**DIAGNOSIS AND COMMENTS**
EX 6	11/25/85 6/19/87 03/28/90 07/22/92 09/07/92 09/11/92 03/17/93 08/29/93 06/02/94 03/30/97 11/18/99	03/21/01	Spitz/Bd & B	0/0
EX 7	02/14/01	01/08/02	Perme	0/0

PULMONARY FUNCTION TEST(S)							
EXHIBIT NO.	**TEST DATE**	**HEIGHT INCHES**	**COOP/ COMPRE-HENSION**	**PHYSICIAN**	**FEV_1**	**MVV**	**FVC**
DX 7		67		ABD	1.87		3.63
DX 31-6	08/01/79 [2]	68"	Good	Seargeant	1.7	60	2.70
DX 31-21	02/21/80 [1]	66"	Poor	Rogers	4.2	58	
DX 31-7	12/15/81	66 1/4	Poor/Poor	Sargent	Maling er-ing		
DX 31-8	04/12/83 [7]	65 1/4	Fair/Good	Seargeant	2.98	39.4	
DX 32-5	02/19/93 [7]	66"	Coop-good; comp.-fair	Hudson	1.95	69	3.57
DX 26	02/17/95 [7]			Vaezy	1.79		3.1
DX 26	03/03/95 [7]	67	?	Vaezy	2.29		3.64
DX 26	05/02/95 [7]		?	Vaezy	2.02		3.31
DX 26	08/11/95 [7]	67"	?	Vaezy	1.56		2.8
	05/21/97	66"		Kabir	2.56	66	4.67
DX 33-4	01/21/98 [7]	67"	Good	Hudson	1.94	56	3.89
	01/23/99	66"		Kabir	1.87	1.11	
DX 33-14	02/25/99 [3, 7]	66"	Good	Robinette	1.67		3.86

PULMONARY FUNCTION TEST(S)							
EXHIBIT NO.	**TEST DATE**	**HEIGHT INCHES**	**COOP/ COMPRE-HENSION**	**PHYSICIAN**	**FEV_1**	**MVV**	**FVC**
					2.03	124	4.76
DX 4	05/26/99 [6, 7]	67"	Good	Seargeant	1.54		3.1
DX 7	06/30/99 [4, 7]			Seargeant	1.73		3.37
DX 23	12/03/99 [7]		Less than optimal	Dahhan	1.89	Invalid	3.5
CX 1	02/14/01 [8]	66"	Good	Rasmussen	1.30	35	3.09
					1.64	50	4.16

1 Invalid Burki 12/4/82, 31-24, invalid McQuillian 07/11/81
2 Invalid Burki 12/4/80 (8/1/79); 31-24, invalid McQuillian, 31-24, 31-6, invalid 07/11/81
3 Valid 4/12/83 vents, report date 6/30/83, DX. 31-8
4 Invalid Michos DX8 7/29/99
5 Invalid Michos 6/30/99 DX5
6 Invalid Michos 3/2/00, DX. 28
7 Invalid Fino 3/22/01, EX 8
8. Valid Fino 9/12/02, EX 9

BLOOD GAS TEST(S)							
EXHIBIT NO.	**TEST DATE**	**ALTITUDE**	**PHYSICIAN**	**PO_2**	**PCO_2**	**COMMENTS**	**QUALIFY**
DX 31-11	08/01/79	Not given	Seargeant	84.0	35		
DX 31-6			exercise	100	30		
DX 32-7	02/19/93	0-2999	Hudson	79.9	36.1		
			exercise	84.0	32.4		
DX 33-6	01/21/98	0-2999	Hudson	79	38.2		
			exercise	87	38.3		
DX 33-14	02/25/99	Not noted	Robinette	70.0	32.3		
DX 10	05/26/99	?	Seargeant	92	36.3		
			exercise	93.1	36.2		
DX 23	12/03/99	?	Dahhan	72.1	37.2		
			exercise	79.4	36.7		
CX 1	02/14/01		Rasmussen	71	33	marked impairment in oxygen transfer during very light exercise	
				60	34		

MEDICAL REPORTS				
EXHIBIT NO.	**REPORT DATE**	**EXAM DATE**	**PHYSICIAN AND QUALIFICATIONS**	**FINDINGS AND DIAGNOSIS**
DX 25	Various		Cortez	Breathing problems, arthritis, back pain
DX 33-5			Hudson	Chronic obstructive bronchitis, simple CWP, ASHD, obstruction on PFT's. Unable to say how much smoking vs mining related
DX 31-10	08/01/79		Seargeant	No active pulmonary disease
DX 31-21	02/21/80		Rogers	Does not have any significant degree of CWP, no pulmonary impairment
DX 31-9	03/18/85	07/19/82 08/09/82 03/12/85	Walker	COPD, emphysema and chronic bronchitis
DX 32-6	02/19/93		Hudson	Chronic obstructive bronchitis, obstruction on PFT's due to smoking & mining
DX 26	02/21/95		Vaezy	COPD
DX 25	05/21/97		Kabir	Obstructive airway disease, emphysema the predominant process
DX 25	07/24/97		Kabir	Obstructive lung disease CAD, CWP, emphysema predominant process
DX 33-9	10/08/97		Kabir	COPD, CAD, CWP
DX 33-14	02/25/99		Robinette	CWP, COPD, ASCUD
DX 9	05/26/99		Seargeant	COPD etiology undetermined
DX 23	12/07/99	12/03/99	Dahhan/Bd cert. & B	No objective pulmonary evidence of CWP, COPD can continue usual coal mine employment, COPD due to smoking
EX 8	03/16/01		Branscomb/B Reader	No CWP, mild respiratory impairment not caused by employment, can return to usual coal mine employment
EX 8	03/22/01		Fino/Bd cert. pulmonary & B reader	No occupational lung disease, no respiratory impairment
CX 1	02/14/01		Rasmussen	"Coal mine dust exposure" must be considered a "major contributing factor" .
CX 2 see also DX 33-9, DX 25	05/97 to 06/19/02		Kabir	1. Uncontrolled chronic obstructive pulmonary disease 2. Severe obstructive airway disease with significant reversible component. 3. Coronary artery disease. 4. pneumoconiosis
EX 9	09/12/02		Fino	Rasmussen's results are valid

The Claimant's treating physician has been Humayun M. Kabir, M.D., Applachia Health

Services, who has been seeing Mr. Evans since May, 1997. Since the early 1980's, the claimant has complained about problems breathing, exacerbated by exertion, but present even when sleeping. Over time, Mr. Evans had been diagnosed by Dr. Kabir as having a combination of medical impairments, including heart disease, chronic obstructive pulmonary disease and pneumoconiosis. With other medications, Mr. Evans tried courses of prednisone, a steroid. Sleep apnea had been considered. By June, 2002, the Claimant reported progressive increased shortness of breath. According to the reports (CX 2), he had severe chronic obstructive pulmonary disease with a "good" reversible component. This was documented in a January, 1999 pulmonary function test where the FEV1 was noted as "only" 39% of the predicted amount and was noted to have improved by 65% after administration of a bronchodilator. He was initially prescribed bronchodilators, such as, oral Theophylline, oral Singulair and an Aerobid inhaler. For a time, the Claimant improved, but he regressed. As of the last office visit to Dr. Kabir, in June, 2002, the Claimant had been taking Theodur, a Serevent inhaler, with Albuterol and Atrovent. His symptoms were reported as "not under control rather progressively going downhill. He has both daytime as well as nocturnal symptoms. He can do his day to day work but gets out of breath easily. Has some cough which is nonproductive. At night he wakes up once or twice with some shortness of breath." Id. On examination, bilateral rhonchi were noted, but the chest appeared to be soft., but not tender, non-distended, without signs of organomegaly. No clubbing, edema or cyanosis was noted. Dr. Kabir found:

1. Uncontrolled chronic obstructive pulmonary disease.
2. Severe obstructive airway disease with significant reversible component.
3. Coronary artery disease.
4. Coal workers pneumoconiosis

Dr. Kabir recommended a repeat pulmonary function test. Anti-inflammatory therapy was prescribed, in addition to the bronchodilators. The Claimant did not want to take "to (sic) many pills. I will reveiew his pulmonary function test and will talk to him again about the maintenance medications."

Apparently, the only X-ray relied upon by Dr. Kabir was one performed in 1997 (CX 2, see notation dated November 11, 1999).

The test referred to above was probably the testing performed by Emory Robinette, M.D., who examined the Claimant February 5, 1999 The Claimant reported to Dr. Robinette that he had quit smoking fifteen years prior to the examination. Dr. Robinette assumed that the Claimant had a 15 pack year smoking history that had ended about 1984 (DX 33-14). He determined the following diagnoses:

1. Simple coal worker s pneumoconiosis.
2. Moderate obstructive lung disease with response to bronchodilator therapy.
3. Moderate impairment of the diffusion capacity consistent with underlying emphysema and dust reticulation.
4. ASCVD with a history of a previous myocardial infarction.
5. Prostate asymmetry with a nodular density in the superior aspect of the left prostate lobe.

According to Dr. Robinette, Mr. Evans complained about increasing shortness of breath and dyspnea. Dr. Robinette assumed a "substantial dust exposure" from twenty three years of coal mine employment. .Evidence of diminished breath sounds in both lung fields with bilateral expiratory wheezes present was reported:

> There was moderate prolongation of the expiratory phase.... X-rays were felt to be consistent with dust reticulation with a profusion abnormality of 1/0, predominant S/T abnormalities. There was bilateral apical pleural scarring present and emphysema present. Functionally, there is evidence of airflow obstruction with an FEV1 of 1.67 or 59% of predicted and an FVC of 3.86 or 97% of predicted. There was response to bronchodilator therapy. The diffusion capacity was reduced at 59% of predicted. These findings would suggest that Mr. Evans does have evidence of interstitial pulmonary process that is associated with airflow obstruction. Although is response to bronchodilator therapy there is is little historical evidence to suggest a clinical diagnosis of asthma. Obvious, Mr. Evans

probably needs a bronchodilator on a regular basis. Based on his pulmonary reserve with an FEV1 of 1.67 or 59% of predicted, Mr. Evans is disabled from working as an underground coal miner. In view of his minimal smoking history, I feel the majority of his pulmonary impairment has occurred as a consequence of his prior coal dust exposure and his radiographic abnormalities. Certainly, this is contributing to his impairment of the diffusion capacity and airflow obstruction.

DX 33-14.

The Claimant was examined on May 26, 1999 for the Department of Labor by Lee Seargeant, Jr., M.D. at LaFollette Medical Center, LaFollette, Tennessee. Dr. Seargeant found that Mr. Evans has chronic obstructive pulmonary disease but he did not find that pneumoconiosis was present. (DX 4, DX 9, DX 10). X-rays taken that day were read by Thomas Cohen and J. Nicholas Sargent, M.D. for the Department of Labor (DX 11 and DX 12). Neiother reader found any evidence of pneumoconiosis. The Claimant was examined for the Employer by A. Dahhan, M.D. on December 3, 1999 (DX 23). The reported history noted frequent wheezing, treatment with two bronchodilators, and occasional non-exertional chest pain. Pulmonary function studies revealed normal FVC and a "mild" reduction in FEV1 on tests that were considered as sub-optimal with invalid components. Dr. Dahhan rendered a diagnosis of mild chronic obstructive pulmonary disease and with no dust related disease or pneumoconiosis.

The Claimant was examined by D.L. Rasmussen, M.D. on February 14, 2001. Mr. Evans reported that he first began to smoke regularly at age 25 in l961, and that he smoked an average of one (1) pack of cigarettes a week, until he quit smoking cigarettes in 1986. He admittedly occasionally continues to smoke a pipe. He told Dr. Rasmussen that his father had emphysema, black lung, and a stroke. No history of hypertension, heart disease, tuberculosis, diabetes, cancer, asthma, or allergies was reported.[7]

Mr. Evans told Dr. Rasmussen that he began to work in small truck mines in the 1950's; then:

> He shot and loaded coal for about 8 [or more] years. He was then employed between 1960 and 1984 regularly. He worked as a hand loader, shot firer, pulled coal by ponies, rock dusted. He worked underground a total of 8+ years. He then worked 14-15 years on surface mining primarily as a drill operator. His last job was that of general laborer on surface mining. He used jack hammers. He loaded holes with 50 pound bags of explosives, some 10-15 per hole. He had to carry some 60 feet. He shovelled holes. He pushed equipment and dragged lines. Thus, he did considerable heavy manual labor. He states he has a total of 25 years of coal mine employment and has been given credit for 23 years.

On examination, no abnormalities of Mr. Evans' eyes, ears, nose, or pharynx were noted. Neck veins appeared flat. Carotid arteries appeared to be palpable. No bruits were heard. No adenopathy or thyroid enlargement were noted. Chest expansion seemed reduced. Diaphragms Appeared low. Breath sounds are noted as "markedly reduced". No rales or rhonehi were noted, but there were prolonged expiratory phase and wheezing with forced respirations noted by Dr. Rasmussen. Heart tones were reduced. Rhythm was regular, with no murmurs, gallops, or clicks. The abdomen appeared soft and non-tender. The liver was noted as descended, but not enlarged. Some right upper quadrant tenderness was noted. Genitalia was normal. Rectal was deferred. Dr. Rasmussen could not feel popliteal or foot pulses. There was no edema. There was no clubbing. Deep tendon reflexes were physiologic. There were no cervical, axillary, epitrochlear or inguinal adenapathy and no gross skin lesions.

An X-ray interpreted by Manu N. Patel, M.D., "a Board Certified Radiologist and B-Reader", indicated pneumoconiosis s/s with a profusion of 1/1 throughout all lung zones.

Dr. Rasmussen noted that an electrocardiogram is consistent with a previous heart attack.

Pulmonary function studies revealed severe, partially reversible obstructive insufficiency. Maximum breathing capacity was noted as "markedly reduced. Single breath carbon monoxide

[7] Note that a previous heart attack is noted elsewhere in the report.

diffusing capacity markedly reduced. There was minimal resting hypoxia." Dr. Rasmussen noted that Mr. Evans underwent an incremental treadmill exercise study,

> beginning at 1.5 mph at a 0% grade. This level was maintained for 3 minutes. Thereafter, the grade of the treadmill was increased 2% per minute. He exercised for 6 minutes and reached a maximum of 1.5 mph at a 6% grade. He achieved an oxygen uptake of only 11.3 cc/kg/mm. which is 38% of his predicted maximum oxygen uptake. He denied chest pain. His ERG and blood pressure responses were normal. He did not exceed his anaerobic threshold at this light exercise level. Heart rate was at least minimally excessive. Volume of ventilation was markedly increased. He retained a breathing reserve of only 27 L/min. There was significant increase in VD/VT ratio and arterial to end tidal PC~2 of +5.9. There was marked impairment in oxygen transfer. He was at least minimally hypoxic.

Id. Dr, Rasmussen determined that Mr. Evans is totally disabled based on a history of heavy manual labor.

Dr. Rasmussen noted that there are three apparent risk factors present. A history of cigarette smoking and a history suggestive of hyperactive airways disease or asthma are noted. However, Dr. Rasmussen determined that the bulk of his impairment,

> is secondary to his occupational dust exposure with resultant pneumoconiosis. Any component of asthma would not produce a marked reduction in single breath carbon monoxide diffusing capacity and would not be expected to produce marked remodeling of the airways. Both cigarette smoking and coal mine dust exposure could produce ventilatory impairment and impairment in oxygen transfer.

CX 1, p. 3.

He determined that "coal mine dust exposure" must be considered a "major contributing factor" to the respiratory insufficiency. He concluded that the studies indicate marked loss of respiratory function as reflected by the significant ventilatory impairment, the marked reduction in diffusing capacity, and the marked impairment in oxygen transfer during very light exercise. In Dr. Rasmussen's opinion,

> This degree of impairment would render this patient totally disabled for resuming his last regular coal mine job with its attendant requirement for heavy manual labor.

Id.

The x-ray that was read as positive by Dr. Patel was read as negative by Jerome F. Wiot, M.D., who is a board certified "B" reader. Dr. Wiot noted that there is evidence of old rib fractures and a calcified granuloma adjacent to the left helium. He noted that the lungs, however, were "somewhat over expanded, consistent with emphysema." EX 4. Likewise, Charles M. Perme, M.D., also found no evidence of pneumoconiosis (EX 7). Likewise, he noted there was evidence of old rib fractures, bilateral upper zone emphysema and borderline enlarged pulmonary arteries that raise the possibility of pulmonary hypertension.

After a review of all of the records relating to evidence prior to the February 2001 examination contained in CX 1, Dr. Gregory Fino, M.D., determined that there is insufficient objective medical evidence to justify a diagnosis of simple coal workers' pneumoconiosis, Mr. Evans does not suffer from an occupationally acquired pulmonary condition, there is no respiratory impairment present, and from a respiratory standpoint, Mr. Evans is "neither partially nor totally disabled from returning to his last mining job or a job requiring similar effort. ...Even if I were to assume that this man has medical or legal pneumoconiosis. it has not contributed to his disability. He would be as disabled had he never stepped foot in the mines." EX 8.

Similarly, Ben V. Branscomb, M.D. determined, without benefit of Dr. Rasmussen's report, that there was no objective evidence or reasonable medical basis documented in the record to diagnose pneumoconiosis,

> nor any other condition or impairment caused or aggravated by CWP or by exposure to coal mine dust. Mr. Evans may be disabled by heart disease and other non-pulmonary problems although the extent of such a disability is not documented. He probably does have mild COPD. If he has it is neither caused nor aggravated by coal mine dust. It is caused by cigarette smoking in a susceptible subject. Taken in whole, and bearing in mind the smoking history obtained in a non—compression setting and also my comments

concerning cigar and pipe smoke there is ample indication of a sufficient tobacco exposure to result in mild (or even severe) COPD. There is an insufficient objective basis for concluding any COPD is more than mild. There is no pulmonary impairment sufficient to prevent his previous coal mine jobs or similar work demands.
Some fourteen attempts at simple pulmonary function studies have been made without obtaining a valid test. There is no valid objective medical evidence of any pulmonary impairment of any etiology.
I am cognizant of the obstructive manifestations which have been associated with coal mine dust and with CWP. Mr. Evans diagnosed symptoms and findings are not consistent with coal dust related obstructive impairment. He has no illness or impairment caused or significantly aggravated by coal mine dust.

EX 8.

The evidence submitted by the Claimant from Dr. Kabir and Dr. Rasmussen was admitted at hearing, but the record remained open post hearing to permit the Employer to respond. Neither Dr. Fino or Dr. Branscomb commented on the evidence in CX 1 and CX 2. All that was said is that the pulmonary function test results were acceptable, according to Dr. Fino (CX 9).

Coal Mine Experience

If a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b). The ten year presumption cannot be used as a bootstrap to prove the existence of pneumoconiosis. A miner with ten years of coal mine employment is not presumed to have pneumoconiosis; rather, he or she must establish the existence of pneumoconiosis by a preponderance of the evidence. Once the existence of pneumoconiosis is established, however, the causal connection between the pneumoconiosis and the coal mine employment is presumed if the miner has ten years of coal mine employment. Because pneumoconiosis can be defined as a lung disease significantly related to or substantially aggravated by dust exposure in coal mine employment (§ 718.201), the existence of pneumoconiosis and the cause of the pneumoconiosis are sometimes merged in the definition. The claimant, however, still bears the burden of establishing both that he or she has pneumoconiosis and that the pneumoconiosis arose out of coal mine employment.

On his application, Mr. Evans alleged 20 years of coal mine employment ending on May 1, 1983. He worked in both underground and surface mines. The last coal mine work he did involved loading the blasting holes and shooting the coal at a strip mine site. The parties stipulated that Mr. Evans spent in excess of ten (10) years in coal mine employment (Tr 32). Mr. Evans testified that he had worked about 20 years in the mines; eight in underground mining and the remainder in strip mining (Tr 14-15). He last worked for Dixie Pine Coal Company and left work in 1983 or 1984 (Tr 15). Later he stated that he left coal mine employment in 1980 (Id.). The Dixie Pine job was at a strip mine (Tr 19). Work at Harris Branch Coal Company and John Van Huss involved underground mine work (Id.).

The claimant bears the burden of establishing the length of his or her coal mine employment. ***Shelesky v. Director, OWCP***, 7 B.L.R. 1-34 (1984); ***Niccoli v. Director, OWCP***, 6 B.L.R. 1-910 (1984); ***Rennie v. U.S. Steel Corp***., 1 B.L.R. 1-859 (1978). The administrative law judge must make a specific, complete finding on this issue. ***Boyd v. Director, OWCP***, 11 B.L.R. 1-39 (1988).

I have examined the earnings record and company statements (DX 31-2, DX 3, DX 4, DX 31-3,DX 31-4, DX 31-22 - statement of Karen Evans, DX 32-2, DX 32-3, DX 32-10, DX 32-12, DX 33-2, and DX 33-5). The Director determined that "at least" nineteen (19) years of coal mine employment has been established, primarily based on the Social Security records. Although the Claimant testified that he worked twenty years, I find that he worked nineteen years in coal mine employment.

Evaluation of the Medical Evidence

Prior to the submission of Dr. Rasmussen's report, the evidence clearly showed that the

Claimant either did not suffer from pneumoconiosis, and even if he had, any respiratory problems were produced by tobacco usage. See DX 33.

Although the Claimant had requested modification, the only "new" evidence submitted was the report of Dr. Robinette, which was not really new, as his ventilatory studies have been discredited by Dr. Fino's evaluation of them. The claim was re-filed as a duplicate claim, and the Department of Labor examinations did not add anything of value to the Claimant's case for an allegation regarding a change of circumstances. However, for reasons fully set forth below, Dr. Rasmussen's report provides new and material evidence, and combined with new evidence from Dr. Kabir, it is reasonable that the new evidence differs "qualitatively" from evidence submitted with the prior claim and therefore. a material change in conditions is established. See ***Sharondale Corp. v. Ross***, 42 F.3d 993 (6th Cir. 1994).

In ***Crace v. Kentland-Elkhorn Coal Corp***., 109 F.3d 1163 (6th Cir. 1997), the court held that the denial of benefits by an administrative law judge was supported by substantial evidence in the record:

> Recent evidence is particularly important in black lung cases, where because of the progressive nature of pneumoconiosis, more recent evidence is often accorded more weight. The most recent administrative law judge was presented with a new, more complete picture of Mr. Crace's health. His determination (denying benefits) was supported by substantial evidence.

To this end, I have the discretion to accord more weight to the results of a recent ventilatory study over those of an earlier study. ***Coleman v. Ramey Coal Co.***, 18 B.L.R. 1-9 (1993). Moreover, a medical report containing the most recent physical examination of the miner may be properly accorded greater weight as it is likely to contain a more accurate evaluation of the miner's current condition. ***Gillespie v. Badger Coal Co.***, 7 B.L.R. 1- 839 (1985). See also ***Bates v. Director, OWCP***, 7 B.L.R. 1-113 (1984) (more recent report of record entitled to more weight than reports dated eight years earlier); ***Kendrick v. Kentland-Elkhorn Coal Co.***, 5 B.L.R. 1-730 (1983).

In ***Wolf Creek Collieries v. Director, OWCP [Stephens],*** 298 F.3d 511 (6th Cir. 2002)1 , the court held that an ALJ properly accorded greater weight to the opinion of the miner's treating physician, who examined the miner on numerous occasions from 1981 through 1989, as opposed to the opinions of employer's physicians who never examined the miner or who only examined the miner once in 1981. Citing to ***Tussey v. Island Creek Coal Co.***, 982 F.2d 1036 (6th Cir. 1993), the court stated that the opinions of treating physicians are not "presumed" to be entitled to greater weight, but they must be "properly weighed and credited." Further, although the court found that the amended regulatory provisions at 20 C.F.R. § 718.104(d) were not directly applicable because the evidence was developed prior to January 19, 2001, it did state that these provisions were "instructive."

Pneumoconiosis

Pneumoconiosis under the Act is defined as both clinical pneumoconiosis and/or any respiratory or pulmonary condition significantly related to or significantly aggravated by coal dust exposure (legal pneumoconiosis):

For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, progressive massive fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment. For purposes of this definition, a disease "arising out of coal mine employment" includes any chronic pulmonary disease resulting in respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. 20 C.F.R. § 718.201.

The existence of pneumoconiosis may be established through the following four methods:

(1) chest x-rays;
(2) autopsy or biopsy;
(3) the presumptions contained at §§ 718.304, 718.305, or 718.306; or

(4) a physician exercising sound medical judgment based on objective medical evidence. 20 C.F.R. § 718.202(a).

A. Chest roentgenogram (x-ray) evidence

Under § 718.202(a)(1), a chest x-ray conducted and classified in accordance with § 718.102, may form the basis for a finding of the existence of pneumoconiosis. Box 2B(c) of the standard x-ray form indicates the quantity of opacities in the lung and, therefore, the presence or absence of pneumoconiosis. The more opacities noted in the lung, the more advanced the disease. There are four categories from which a physician may choose[8]:

0 = small opacities absent or less profuse than in category 1.
1 = small opacities definitely present but few in number.
2 = small opacities numerous but normal lung markings still visible.
3 = small opacities very numerous and normal lung markings are usually partly or totally obscured.

If no categories are chosen, then the x-ray report is not classified according to the standards adopted by the regulations and cannot, therefore, support a finding of pneumoconiosis. Likewise, an x-ray which is interpreted as Category 0 (--/0, 0/0, 0/1) demonstrates, at most, only a negligible presence of the disease and will not support a finding of pneumoconiosis under the Act or regulations.

If the physician determines that the study is Category 1 (1/0, 1/1, ½), Category 2 (2/1, 2/2, 2/3), or Category 3 (3/2, 3/3, 3/+), then there is a definite presence of opacities in the lung and the x-ray report may be used as evidence of the existence of pneumoconiosis. An interpretation of 1/0 is the minimum reading under the regulations which will support a finding of pneumoconiosis. This reading (1/0) indicates that the physician has determined that the x-ray is Category 1 but he or she seriously considered Category 0. As another example, a reading of 2/2 indicates that the physician determined that the x-ray was Category 2 and Category 2 was the only other category seriously considered by the physician.

In general, where two or more x-ray reports are in conflict, consideration must be given to the radiological qualifications of the physicians interpreting such x-rays. From 1969 until the February 14, 2001 examination, the record contains ten (10) x-rays, bearing forty one (41) negative readings and four (4) positive readings, with another two (2) that are not conclusive (See DX 31-21 Dr. Rodgers reading 0,1 and DX 33-17, Dr. Pendergrass' reading of a February 19, 1993 X-ray). The four positive x-rays are all marked as 1,0. Dr. Cole, who determined that there was pneumoconiosis on an x-ray dated August 1, 1979, is not board certified (DX 31-12). The same x-ray was read as negative by five (5) board certified radiologists, who are also certified "B" readers and by another physician who is board certified and by a seventh who is not board certified, but is a "B" reader (DX 14, DX 31-13, DX 31 14,DX 31-16, and DX 23). Likewise, A.R.Hudson, M.D., who read x-rays taken February 19, 1993 (DX 32-8) and January 21, 1998 (DX 33-7), is not board certified. Five physicians who are both board certified and are also "B" readers, and a sixth physician who is certified, read the 1993 x-ray as negative (DX 14, DX 32-9, DX 33-17, and DX 23). And four board certified "B" readers read the 1998 x-ray as negative (DX 33-8 and DX 14).

The other positive x-ray was taken February 5, 1999 by Dr. Robinette, who read it as 1,0 (DX 33-14, DX 26). Although Dr. Robinette lists his qualifications on the report as a board

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[8] 20 CFR §**§ 718.102 Chest roentgenograms (X- rays).**

(b) A chest X-ray to establish the existence of pneumoconiosis shall be classified as Category 1, 2, 3, A, B, or C, according to the International Labour Organization Union Internationale Contra Cancer/Cincinnati (1971) International Classification of Radiographs of the Pneumoconioses (ILO-U/C 1971), or subsequent revisions thereof. A chest X-ray classified as Category Z under the ILO Classification (1958) or Short Form (1968) shall be reclassified as Category 0 or Category I as appropriate, and only the latter accepted as evidence of pneumoconiosis. A chest X-ray classified under any of the foregoing classifications as Category 0, including sub-categories 0/-, 0/0, or 0/1 under the UICC/Cincinnati (1968) Classification or the ILO-U/C 1971 Classification does not constitute evidence of pneumoconiosis.

certified “B” reader, Dr. Robinette’s *cirriculum vitae* is not of record. Three (3) board certified radiologist “B” readers read the same x-ray as negative (EX 1, EX 2, EX 3) and a fourth found no pneumoconiosis, but did diagnose chronic obstructive pulmonary disease (Dr. Mullens, DX 26).

Subsequent to the February 5, 1999 x-ray, Mr. Evans was given x-rays on May 26, 1999, November 18, 1999 and December 3, 1999; all readings from these were negative (DX 11-12, DX 23, EX 5, EX 6). The May 26 x-ray was read by two consultants to the Department of Labor.

The February 14, 2001 x-ray was taken and read by Dr. Patel, who is board certified in radiology (See cv, CX 1). Although his report notes in script that it is a “B-reading”, a review of the *curriculum vitae* does not show that Dr. Patel is one. As noted above, Dr. Wiot and Dr. Perme disagree with Dr. Patel. Dr. Wiot is board certified and also is a “B” reader.

B. Autopsy or biopsy

A biopsy or autopsy conducted and reported in compliance with § 718.106 may be the basis for a finding of the existence of pneumoconiosis. 20 C.F.R. § 718.202(a)(2). There is no relevant biopsy evidence in this case.

C. Presumptions related to the existence of pneumoconiosis

The regulations at 20 C.F.R. § 718.202(a)(3) provide that "[i]f the presumptions described in §§ 718.304, 718.305 or 718.306 are applicable, it shall be presumed that the miner is or was suffering from pneumoconiosis." 20 C.F.R. § 718.202(a)(3).

1. Complicated pneumoconiosis

Under § 718.304, there is an irrebuttable presumption that a miner is totally disabled due to pneumoconiosis, if the miner is suffering from complicated pneumoconiosis. No evidence of complicated pneumoconiosis is present in this record..

2. Fifteen years of coal mine employment

Under § 718.305, if a miner was employed for fifteen years or more in one or more underground coal mines, and if other evidence demonstrates the existence of a totally disabling respiratory or pulmonary impairment, then there shall be a rebuttable presumption that such miner is totally disabled due to pneumoconiosis. 20 C.F.R. § 718.305(a). A spouse's affidavit or testimony may not be used by itself to establish the applicability of the presumption. 20 C.F.R. § 718.305(a). This presumption is not applicable to any claim filed on or after January 1, 1982. 20 C.F.R. § 718.305(e). Since this is a duplicate claim, filed after 1982, this section is not applicable.

D. Reasoned medical opinions

A determination of the existence of pneumoconiosis may also be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 C.F.R. § 718.202(a)(4). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. ***Taylor v. Director, OWCP***, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 C.F.R. § 718.202(a)(4). Quality standards for reports of physical examinations are found at 20 C.F.R. § 718.104. For example, in ***Cornett v. Benham Coal, Inc***., 227 F.3d 569 (6th Cir. 2000), the circuit court held that, if a physician bases his or her finding of coal workers' pneumoconiosis only upon the miner's history of coal dust exposure and a positive chest x-ray, then the opinion "should not count as a reasoned medical judgment under § 718.202(a)(4)."[9]

The Claimant submits that Dr.’s Robinette’s and Rasmussen’s reports are well documented and well reasoned and that they are more compelling than the other opinions of record. A "documented" opinion is one that sets forth the clinical findings, observations, facts,

[9] However, the court found that the opinions of Drs. Veazy and Baker were not, as characterized by the administrative law judge, based only upon the miner's exposure to coal dust. Rather, in addition to consideration of coal mine employment and chest x-rays, the physicians "considered their examinations of Cornett, his history in the mines, his history as a smoker and pulmonary functions studies."

and other data upon which the physician based the diagnosis. ***Fields v. Island Creek Coal Co.***, 10 B.L.R. 1-19 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. ***Hoffman v. B&G Construction Co.***, 8 B.L.R. 1-65 (1985); ***Hess v. Clinchfield Coal Co.***, 7 B.L.R. 1-295 (1984); ***Justus v. Director, OWCP***, 6 B.L.R. 1-1127 (1984). Indeed, a treating physician's opinion based only upon a positive x-ray interpretation and claimant's symptomatology was deemed sufficiently documented. ***Adamson v. Director, OWCP***, 7 B.L.R. 1-229 (1984). A "reasoned" opinion is one in which the administrative law judge finds the underlying documentation and data adequate to support the physician's conclusions. ***Fields***, supra. Indeed, whether a medical report is sufficiently documented and reasoned is for the judge as the finder-of-fact to decide. ***Clark v. Karst-Robbins Coal Co.***, 12 B.L.R. 1-149 (1989)(en banc).

Although Mr. Evans advised Dr. Rasmussen that he first began to smoke regularly at age 25 in l961, and that he smoked an average of one (1) pack of cigarettes a week, until he quit smoking cigarettes in 1986, and that he continues to smoke a pipe, Dr. Rasmussen found that the effect from tobacco is secondary to his occupational dust exposure with resultant pneumoconiosis. In addition to the standard pulmonary function studies, carbon monoxide studies were administered, to test the extent of tobacco usage to the respiratory system. Dr. Rasmussen concluded that any component of asthma would not produce a marked reduction in single breath carbon monoxide diffusing capacity and would not be expected to produce marked remodeling of the airways. Both cigarette smoking and coal mine dust exposure could produce ventilatory impairment and impairment in oxygen transfer. Therefore he includes pneumoconiosis in his diagnosis.

Dr. Fino and Dr. Branscomb do not agree. Dr. Fino found absolutely no respiratory impairment (EX 8). Dr. Branscomb found mild chronic obstructive pulmonary disease. He determined that Mr. Evans may be disabled by heart disease and “other non-pulmonary” problems. In his opinion, if Mr. Evans has chronic obstructive pulmonary disease , “... it is neither caused nor aggravated by coal mine dust. It is caused by cigarette smoking.” Id.

Evidence under all sections must be weighed together

In ***Island Creek Coal Co. v. Compton***, 211 F.3d 203 (4th Cir. 2000), the Fourth Circuit held that an administrative law judge must weigh all evidence together under 20 C.F.R. § 718.202(a) to determine whether the miner suffered from the disease. This is contrary to the Board's view that an administrative law judge may weigh the evidence under each subsection separately, i.e. x-ray evidence at § 718.202(a)(1) is weighed apart from the medical opinion evidence at § 718.202(a)(4). In ***Furgerson v. Jericol Mining, Inc***., 22 B.L.R. 1-__, BRB No. 01-0728 BLA (Sept. 24, 2002)(en banc), a case arising in the Sixth Circuit, the Board declined to apply the Fourth Circuit's holding in ***Island Creek Coal Co. v. Compton***, 211 F.3d 203 (4th Cir. 2000), which required that a determination of the presence of pneumoconiosis be based on weighing all types of evidence under 20 C.F.R. § 718.202 together. Rather, the Board noted that "the Sixth Circuit has often approved the independent application of the subsections of Section 718.202(a) to determine whether claimant has established the existence of pneumoconiosis." [10] In

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[10] The Board has upheld a finding that the x-ray evidence does not establish the existence of pneumoconiosis where that finding was based on the negative report of a B-reader and board-certified radiologist, i.e., the most qualified physician of record found no pneumoconiosis. ***Roberts v. Bethlehem Mines Corp***., 8 B.L.R. 1-211 (1985). The Board has also upheld a finding that the x-ray evidence does not establish the existence of pneumoconiosis where that finding was based on the readers' qualifications and the preponderance of the readings, i.e., the majority of the most qualified B-readers of record found no pneumoconiosis. ***Dixon v. North Camp Coal Co.***, 8 B.L.R. 1-344 (1985).

Under § 718.202(a)(4), "the administrative law judge must consider and weigh all relevant medical evidence to ascertain whether or not claimant has established the presence of pneumoconiosis by a preponderance of the evidence . . .." ***Perry v. Director***, OWCP, 9 B.L.R. 1-1, 1-2 (1986). Where the medical opinions are in conflict, the administrative law judge must discuss the conflicting evidence and provide a rationale for choosing one physician's opinion over another. ***McGinnis v. Freeman United Coal Mining Co.***, 10 B.L.R. 1-4 (1987).

It is also noteworthy that the Board has held that the employer is not required to establish a "cohesive theory" with regard to whether the miner suffers from coal workers' pneumoconiosis, ***Bentley v. Kentucky Elkhorn***

an abundance of caution, I will do both.

The record shows that the Claimant's condition has gotten progressively worse with time (See Dr. Kabir note of June 19, 2002, CX 2, also see DX 33-5; DX 9). As set forth above, I accept that the evidence prior to the filing of this claim showed that the Claimant had failed to prove that he has pneumoconiosis. I note the near unanimity on this issue. The Board has held that I am not required to defer to the numerical superiority of x-ray evidence, ***Wilt v. Wolverine Mining Co.***, 14 B.L.R. 1-70 (1990), although it is within my discretion to do so, ***Edmiston v. F & R Coal Co.***, 14 B.L.R. 1-65 (1990).

On the other hand, to a reasonable degree of probability or certainty, I accept that the Claimant did establish that he had a respiratory impairment, and that the most plausible diagnosis was chronic obstructive pulmonary disease. I note that Dr. Kabir (DX 25, CX 2), the treating physician, Dr. Seargeant (DX 4, 7, and 9), the Department of Labor examining physician, Dr. Dahhan (DX 23), who examined the Claimant for the Employer, Dr. Branscomb (EX 8), who read the record for the Employer, agree with Dr. Robinette and Dr. Rasmussen on this issue. The lone dissent on the existence of chronic obstructive pulmonary disease is Dr. Fino (EX 8,EX 9). And his failure to comment on Dr. Rasmussen's report ameliorates Dr. Fino's earlier position, rendering it meaningless.[11].

By the time that the Claimant was examined by Dr. Robinette in early 1999, the condition had progressed significantly. After an examination of all of that evidence, I do not accept that the evidence prior to that date is relevant or is helpful in determining whether the Claimant has pneumoconiosis since the filing of the current application. However, as of that date, the x-ray evidence and the pulmonary function studies and other evidence were insufficient to prove that the Claimant has pneumoconiosis. On March 22, 2001, Dr. Fino, in reviewing the record determined that Dr. Robinette's pulmonary function studies were deemed as invalid because of a premature termination to exhalation and a lack of reproducibility in the expiratory tracings. "There was also a lack of an abrupt onset to exhalation. The values recorded for this spirometry represent at least the minimal lung function that this man could perform and certainly not this man s maximum lung function." EX 8. Subsequent testing by Dr. Seargeant in May and by Dr. Dahhan in December 1999 also yielded invalid results. Dr. Robinette read his own x-ray as 1,0 while all other readers found it negative. Subsequent x-rays taken May 26 by the Department of Labor and December 3, 1999 for the employer were read as negative. As set forth above, from 1969 until the February 14, 2001 examination, the record contains ten (10) x-rays, bearing forty one (41) negative readings and four (4) positive readings, with another two (2) that are not conclusive (See DX 31-21 Dr. Rodgers reading 0,1 and DX 33-17, Dr. Pendergrass' reading of a February 19,

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Coal, Inc., BRB No. 00-0140 BLA (Apr. 6, 2001) (unpub.).

[11] Vague opinions may be considered unacceptable. In ***Kentland Elkhorn Coal Corp. v. Director, OWCP [Hall***], 287 F.3d 555 (6th Cir. 2002), the Sixth Circuit applied the amended regulatory provisions at 20 C.F.R. § 718.204(b) (2002) and affirmed the ALJ's finding that the miner's total disability was due to coal workers' pneumoconiosis. In so holding, the court concluded that the ALJ properly accorded greater weight to the opinions of Drs. Saha, Younes, and Sikder over the contrary opinion of Dr. Fino on grounds that Dr. Fino's opinion was equivocal or vague. In particular, Dr. Fino concluded that the degree of the miner's obstruction could not be determined, but then concluded that the miner could return to his usual coal mine work. The court found that Dr. Fino's conclusion that the miner could return to his previous coal mine employment to be problematic given that Dr. Fino stated that he could not measure the level of the miner's obstruction. On the other hand, the court found that each of the remaining physicians conducted a "thorough examination" of the miner and found that he was totally disabled. The court noted that, "[c]ombined with the fact that Hall's previous work in the coal mines required heavy exertion and exposure to large amounts of dust, the ALJ properly concluded that Hall was totally disabled as 20 C.F.R. § 718.204(b)(1) defines that term."

1993 X-ray).[12]

Subsequent to the February 5, 1999 x-ray, Mr. Evans was given x-rays on May 26, 1999, November 18, 1999 and December 3, 1999; all readings from these were negative (DX 11-12, DX 23, EX 5, EX 6). The May 26 x-ray was read by two consultants to the Department of Labor.

The February 14, 2001 x-ray was taken and read by Dr. Patel, who is board certified in radiology (See cv, CX 1). Although his report notes in script that it is a "B-reading", a review of the *curriculum vitae* does not show that Dr. Patel is one. As noted above, Dr. Wiot and Dr. Perme disagree with Dr. Patel. Dr. Wiot is board certified and also is a "B" reader.

It is reasonable that the more recent evidence is more probative than the older evidence. ***Clark v. Karst-Robbins Coal Co.***, and ***Casella v. Kaiser Steel Corp***., *supra*. As of June 19, 2002, the Claimant's symptoms that include shortness of breath were characterized as "uncontrolled" (CX 2). There is no contrary evidence to rebut this fact.

With respect to the x-ray readings, Dr. Patel rendered the most recent x-ray. Generally, it is proper to accord greater weight to the most recent x-ray study of record. ***Clark v. Karst-Robbins Coal Co.***, 12 B.L.R. 1-149 (1989)(en banc); ***Casella v. Kaiser Steel Corp***., 9 B.L.R. 1-131 (1986). , supra; ***Stanford v. Director, OWCP***, 7 B.L.R. 1-541 (1984); ***Tokarcik v. Consolidation Coal Co.***, 6 B.L.R. 1-666 (1983).[13] X-rays had been taken in December, May and February, 1999. I note that the treating sources document that the disease was progressing in that symptoms were worsening (CX 2). In weighing x-rays based upon the "later evidence" rule, it is the date of the study, and not the date of the interpretation, which is relevant. ***Wheatley v. Peabody Coal Co.***, 6 B.L.R. 1-1214 (1984).

As noted above, however, Dr. Patel is not as qualified as Dr. Wiot. Greater weight may be accorded the x-ray interpretation of a dually- qualified (B-reader and board-certified) physician over that of a board-certified radiologist. ***Herald v. Director, OWCP***, BRB No. 94-2354 BLA (Mar. 23, 1995)(unpublished). The Board has held that it is also proper to credit the interpretation of a dually qualified physician over the interpretation of a B-reader. ***Cranor v. Peabody Coal Co.***, 22 B.L.R. 1-1 (1999) (en banc on recon.); ***Sheckler v. Clinchfield Coal Co.***, 7 B.L.R. 1-128 (1984). See also ***Roberts v. Bethlehem Mines*** Corp., 8 B.L.R. 1-211 (1985) (weighing evidence under Part 718).

However, I note that neither Dr. Wiot or Dr. Perme found evidence of chronic obstructive pulmonary disease, although they both found emphysema (EX 4 and EX 7).

I note that although both Dr. Branscomb and Dr. Fino are board certified in internal medicine, neither Dr. Kabir's nor Dr. Robinette's credentials have been moved into evidence. Dr. Rasmussen is board certified in internal medicine, is board certified in forensic medicine, is a member of the board of disability analysts, and is also a "B"-reader (CX 1).

I note that the examining physician for the Department of Labor, Dr. Seargeant, found that the Claimant was disabled as a result of chronic obstructive pulmonary disease (DX 9, DX 4, DX 7). I note that this opinion is based in large part, by invalid pulmonary function studies. I note that Dr. Fino found no respiratory deficit, as there are no positive valid studies (EX 8). However the record now discloses that there are valid studies and there is an apparent deficit (EX 9, CX 1).

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[12] The four positive x-rays are all marked as 1,0. Dr. Cole, who determined that there was pneumoconiosis on an x-ray dated August 1, 1979, is not board certified (DX 31-12). The same x-ray was read as negative by five (5) board certified radiologists, who are also certified "B" readers and by another physician who is board certified and by a seventh who is not board certified, but is a "B" reader (DX 14, DX 31-13, DX 31 14,DX 31-16, and DX 23). Likewise, A.R.Hudson, M.D., who read x-rays taken February 19, 1993 (DX 32-8) and January 21, 1998 (DX 33-7), is not board certified. Five physicians who are both board certified and are also "B" readers, and a sixth physician who is certified, read the 1993 x-ray as negative (DX 14, DX 32-9, DX 33-17, and DX 23). And four board certified "B" readers read the 1998 x-ray as negative (DX 33-8 and DX 14).

[13] This is not necessarily true "later evidence" rule where the recent x-ray evidence was negative for the existence of pneumoconiosis, but prior evidence was positive for the disease. ***Woodward v. Director, OWCP***, 991 F.2d 314 (6th Cir. 1993).

Both Robinette and Dr. Rasmussen, who had an opportunity to examine the Claimant, found evidence of chronic obstructive pulmonary disease. Dr. Seargeant and Dr. Dahhan for the Department of Labor and the Employer, respectively, both concur on this issue (DX 4, DX 9, DX 23). Dr. Fino and Dr. Branscomb, reading the same record for the Employer disagree as to whether the Claimant had a respiratory deficit. Dr. Branscomb found mild chronic obstructive pulmonary disease caused by cigarette smoking (EX 8). The opinions of Dr. Robinette and Dr. Rasmussen more consistent with the unravelling of the evidence than Dr. Fino's opinion. And they had a better opportunity to examine the Claimant. Dr. Rasmussen is as qualified as Dr. Fino. And Dr. Fino is not an examining physician. Dr. Seargeant's and Dr. Dahhan's qualifications are not of record.[14] But botyh of them examined the Claimant. Dr. Branscomb has the same qualifications as Dr. Fino (EX 8). I credit the majority opinion that there is evidence of a respiratory condition, notably chronic obstructive pulmonary disease. I note that this opinion is also consistent with Dr. Robinette's opinion, and in pertinent part, that of Dr. Dahhan, who also had the opportunity to examine the Claimant, and found chronic obstructive pulmonary disease (DX 23). I also note that Dr. Kabir, the Claimant's treating physician, who had the opportunity to examine and treat the Claimant on numerous occasions, also rendered a diagnosis of chronic obstructive pulmonary disease. He also noted severe obstructive airway disease with a significant reversible component.

Therefore, I completely discount Dr. Fino's diagnosis, as he did not consider factors beyond the invalid testing, and as even Dr. Branscomb's logic is more rational on this point. And most importantly, Dr. Fino did not provide a contrary opinion to the diagnosis rendered by Dr. Rasmussen, and did not provide a rationale regarding the testing performed in February 2001, beyond acknowledgment that the ventilatory testing was valid[15], and I also find that his rejection of chronic obstructive pulmonary disease is contrary to the probative weight of the evidence.

I also must discount the opinions of Dr. Wiot and Dr. Perme as to their opinions concerning the February 14, 2002 x-ray as their diagnoses are not accurate when the other evidence is considered. The full weight of the evidence, from well qualified internists and pulmonologists shows that the Claimant has chronic obstructive pulmonary disease.

In this case, the Employer's experts assert that if the Claimant has any respiratory deficit, the Claimant's disability is completely due to cigarette smoking (EX 8). The Employer is correct that cigarette smoking may play a significant role in Claimant's respiratory problems. The Employer is also correct that the Claimant made several inconsistent statements concerning the extent of his smoking history. In fact, he told one physician that he had never smoked cigarettes.[16] Mr. Evans told another, Dr. Hudson, who diagnosed pneumoconiosis, that he had smoked thirty four (34) years (DX 33-5).[17] However, Dr. Robinette reported fifteen (15) pack years and Dr. Rasmussen reported approximately twenty five (25) pack years. Dr. Fino had an opportunity to comment on the smoking history, but as he took the position, because so many of the test results were invalid, that there was no record of any respiratory deficit; it is reasonable that is why he did not comment further.

I accept that the Claimant is a poor historian and is uneducated. I expect that there was some confusion and a reliance on unsupported facts rendered in some of the reports rendered prior to the filling of the current application. However, I expect that Dr. Rasmussen's report of Mr. Evans' smoking history and estimate is more probative as it appears to be consistent with the hearing testimony, and is consistent with several other histories. (See DX 25 and CX 2, wherein

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[14] Although the cover letter to DX 23 states that a CV is included, the credentials are not documented.

[15] Other to advise that the pulmonary function studies are valid.

[16] Dr. Rodgers, February 21, 1980 (DX 31-21).

[17] However, Dr. Hudson was unable to determine whether pneumoconiosis or tobacco usage caused total disability.

Mr. Evans told several physicians, including Dr. Kabir, that he had smoked twenty five to thirty years.)

Pneumoconiosis and coal dust exposure and cigarette smoking are not necessarily mutually exclusive under the law. The Sixth Circuit requires that total disability be "due at least in part" to pneumoconiosis. ***Adams v. Director, OWCP***, 886 F.2d 818, 825 (6th Cir. 1989); ***Zimmerman v. Director, OWCP***, 871 F.2d 564, 566 (6th Cir. 1989); ***Roberts v. Benefits Review Board***, 822 F.2d 636, 639 (6th Cir. 1987).[18] I accept that pneumoconiosis does not have to be the sole cause.

Therefore, I must also discount the opinion of Dr. Branscomb, who did not have the recent treatment records before him, did not review the results of the February 2001 pulmonary function studies, x-ray, and Dr. Rasmussen's report before him, and because he inferred that tobacco and pneumoconiosis are mutually exclusive.

I note that Dr. Rasmussen as a board certified internist, forensic examiner, disability analyst and "B"-reader, has qualifications equal to Dr's Fino and Branscomb. I find that his qualifications are more relevant than those of board certified radiologist "B" readers to evaluate crucial components of an examination..

After a review of the entire record, I accept, that based on the recent treatment records and the examination of Dr. Rasmussen and his report, although not perfect, that his diagnosis is more rational and is more cogent than the report of Dr. Fino, and his opinions are more persuasive than the reports of Dr. Wiot and Perme. I find that it is irrational that all of them fail to diagnose chronic obstructive pulmonary disease. ***Fields v. Island Creek Coal Co.***,*supra* and ***Clark v. Karst-Robbins Coal Co.***, *supra*. I find that by failing to comment on the whole of Dr. Rasmussen's report, Dr. Fino has discounted his prior report. I give greater weight to the reading of Dr. Patel, although he is not as qualified, because his opinions are closer to the full weight of all of the evidence, in that chronic obstructive pulmonary disease is documented. I note that Dr. Rasmussen performed specific testing and to consider smoking as an exclusive source, that he considered the various possible sources, and that he accepts that smoking has an effect on the overall respiratory condition, but finds that pneumoconiosis is a "major contributing factor". I accept that this position is rational and that is reflects the law of the 6th Circuit. For these reasons, I discount the opinion of Dr. Branscomb. I also note that both Dr. Branscomb and Dr. Fino never met the claimant and I accord significance to the fact that Dr. Rasmussen personally examined the Claimant. ***Cole v. East Kentucky Collieries***, 20 B.L.R. 1-51 (1996) (the administrative law judge acted within his discretion in according less weight to the opinions of the non-examining physicians; Moreover, none of the other physicians fully commented or even took into consideration Dr. Rasmussen's examination, and I accept the proposition found in Dr. Kabil's reports, that Mr. Evans has a progressive disease that has gotten progressively worse.[19]

Therefore, I accept that the evidence shows that Mr. Evans has established that he has pneumoconiosis through the February, 2001examination of Dr. Rasmussen. 20 CFR 718.202(a)(4).

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[18] The Seventh Circuit holds that pneumoconiosis must be a "*simple* contributing cause" of the miner's total disability (pneumoconiosis must be a necessary, but need not be a sufficient, cause of miner's total disability). ***Hawkins v. Director, OWCP***, 907 F.2d 697, 707 (7th Cir. 1990); ***Shelton v. Director, OWCP***, 899 F.2d 690, 693 (7th Cir. 1990). The Tenth Circuit requires that the pneumoconiosis be "at least *a contributing cause*." ***Mangus v. Director, OWCP***, 882 F.2d 1527, 1531 (10th Cir. 1989) (emphasis added).

[19] In ***Gray v. Peabody Coal Co.***, Case No. 01-3083 (6th Cir. Apr. 19, 2002)(unpublished), the Sixth Circuit held that the ALJ erred in according greater weight to the consultative opinions of Drs. Fino and Branscomb over the opinion of a treating physician on grounds that Drs. Fino and Branscomb had superior credentials. Citing to ***Tussey v. Island Creek Coal Co.***, 9982 F.2d 1036 (6th Cir. 1993), the court held that an ALJ may discount a treating physician's opinion if it is "not well reasoned or well documented, or is problematic in some other way." However, the court stated that "[w]here the ALJ determines that the treating physician's opinion is well reasoned and well documented, the ALJ must give more weight to that opinion than to those of other physicians, even where those other physicians have superior qualifications."

Etiology of the Pneumoconiosis

Once it is determined that the miner suffers (or suffered) from pneumoconiosis, it must be determined whether the miner's pneumoconiosis arose, at least in part, out of coal mine employment. 20 C.F.R. § 718.203(a). If a miner who is suffering from pneumoconiosis was employed for ten years or more in one or more coal mines, there is a rebuttable presumption that the pneumoconiosis arose out of such employment. 20 C.F.R. § 718.203(b).

The parties have stipulated to ten years' exposure. And again, Dr. Rasmussen directly offers that coal mining produced the pneumoconiosis, which is a "major contributing factor" to a disability. As the Employer has failed to provide rebuttal to Dr. Rasmussen's opinions, it has also failed to rebut the presumption.

Total Disability

A miner shall be considered totally disabled if he or she has complicated pneumoconiosis (§ 718.304) or if pneumoconiosis prevents him or her from doing his usual coal mine employment or comparable and gainful employment (§ 718.204(b)).

Section 718.204(c) provides that, in the absence of contrary probative evidence, evidence which meets the quality standards of the subsection shall establish a miner's total disability. The administrative law judge cannot merely weigh like/kind evidence. Specifically, it is error to look at all the pulmonary function studies and conclude that the miner is totally disabled, or to look at all the blood gas studies to conclude that the miner is totally disabled. The administrative law judge must consider all the evidence of record and determine whether the record contains "contrary probative evidence." If so, the administrative law judge must assign this evidence appropriate weight and determine "whether it outweighs the evidence supportive of a finding of total respiratory disability." ***Troup v. Reading Anthracite Coal Co.***, 22 B.L.R. 1-11 (1999) (en banc); ***Fields v. Island Creek Coal Co.***, 10 B.L.R. 1-19, 1-21 (1987); ***Shedlock v. Bethlehem Mines Corp***., 9 B.L.R. 1-195, 1-198 (1986).

Dr. Rasmussen's pulmonary function studies showed the following:

Exhibit	Date	Height	FEV1	MVV	FVC
CX 1	02/14/01 [8]	66"	1.30	35	3.09
			1.64	50	4.16

I note that there is a conflict in the evidence concerning the Claimant's age. Dr. Rasmussen reported that the Claimant was sixty five years old on the date of examination, in February, 2001.If the Claimant was born on October 18, 1938 (DX 1), he was sixty two years of age on that date. However, earlier applications (DX 31-1, DX 32-1, DX 32-11, DX 33-1, DX 33-5) show that he was born October 18, 1936. His testimony at hearing is more consistent with the 1936 date. I also note that this is also true of the numerous recordings of the Claimant's date of birth in the medical records. Therefore I accept that the date of birth set forth in the application is incorrct.

There is also a conflict as to height. I note that these vary from sixty six to sixty eight inches. I accept that Dr. Rasmussen's measurement is accurate.

As stated earlier, there is no evidence that challenges Dr. Rasmussen's results as to validity.

However, although Dr. Rasmussen noted that the pulmonary function studies revealed severe, partially reversible obstructive insufficiency, and the maximum breathing capacity was noted as "markedly reduced", the values obtained do not meet the criteria set forth by the tables.

The Blood-Gas findings are as follows:

EXHIBIT NO.	TEST DATE	ALTITUDE	PHYSICIAN	PO_2	PCO_2	COMMENTS
CX 1	02/14/01		Rasmussen	71	33	marked impairment in oxygen transfer during very light exercise
				60	34	

Dr. Rasmussen noted that there were significant gas transfer deficits. A review of the record shows that the testing was administered in Beckley, West Virginia. It is noteworthy that the Board and some circuit courts have emphasized that pulmonary function and blood gas testing measure different types of impairment. In ***Tussey v. Island Creek Coal Co.***, 982 F.2d 1036, 1040-41 (6th Cir. 1993), the court noted that the Board has held that the results of blood gas and pulmonary function testing "may consistently have no correlation since coal workers' pneumoconiosis may manifest itself in different types of pulmonary impairment."' The court cited to ***Gurule v. Director, OWCP***, 2 B.L.R. 1-772, 1-777 (1979), *aff'd.*, 653 F.2d 1368 (10th Cir. 1981). See also ***Sheranko v. Jones and Laughlin Steel Corp***., 6 B.L.R. 1-797, 1-798 (1984) (blood gas studies and ventilatory studies measure different types of impairment).

If the altitude were between seal level and 2, 999 feet, the findings meet the criteria established by the Blood -Gas Tables in Appendix C to Part 718. I take administrative notice that Beckley, West Virginia, is with that range.[20]

I note that Dr. Rasmussen was well qualified to administer and evaluate the test results.

The Employer was given an opportunity post hearing to contest the results and the validity odf the testing but did not do so. In order to render a blood gas study unreliable, the party must submit a medical opinion that a condition suffered by the miner, or circumstances surrounding the testing, affected the results of the study and, therefore, rendered it unreliable. ***Vivian v. Director, OWCP***, 7 B.L.R. 1-360 (1984) (miner suffered from several blood diseases); ***Cardwell v. Circle B Coal Co.***, 6 B.L.R. 1-788 (1984) (miner was intoxicated). Similarly, in ***Big Horn Coal Co. v. Director, OWCP [Alley***], 897 F.2d 1045 (10th Cir. 1990) and ***Twin Pines Coal Co. v. U.S. DOL***, 854 F.2d 1212 (10th Cir. 1988), the court held that the administrative law judge must consider a physician's report which addresses the reliability and probative value of testing wherein he or she attributes qualifying results to non- respiratory factors such as age, altitude, or obesity.

The Employer has failed to raise any of those concerns and I find that the arterial blood gas studies are conforming to 20 CFR § 718.204(c)(2) and that total disability has been presumptively established.

Etiology of Total Disability

Unless one of the presumptions at §§ 718.304, 718.305, or 717.306 is applicable, a miner with less than 15 years of coal mine employment, must establish that his or her total disability is due, at least in part, to pneumoconiosis. The Board has held that "[i]t is [the] claimant's burden pursuant to § 718.204 to establish total disability due to pneumoconiosis . . . by a preponderance of the evidence." ***Baumgartner v. Director, OWCP***, 9 B.L.R. 1-65, 1-66 (1986); ***Gee v. Moore & Sons***, 9 B.L.R. 1-4, 1-6 (1986)(en banc). The Board requires that pneumoconiosis be a "contributing cause" to the miner's disability. ***Scott v. Mason Coal Co.***, 14 B.L.R. 1-37 (1990) (en banc), overruling ***Wilburn v. Director, OWCP***, 11 B.L.R. 1-135 (1988). The Sixth Circuit requires that total disability be "due at least in part" to pneumoconiosis. ***Adams v. Director, OWCP***, 886 F.2d 818, 825 (6th Cir. 1989); ***Zimmerman v. Director, OWCP***, 871 F.2d 564, 566 (6th Cir. 1989); ***Roberts v. Benefits Review Board***, 822 F.2d 636, 639 (6th Cir. 1987). However, in ***Peabody Coal Co. v. Smith***, 127 F.3d 504, 507 (6th Cir. 1997), the Sixth Circuit held that, although pneumoconiosis need only be a "contributing cause" to the miner's total disability, a claimant must demonstrate that the disease was more than a de minimus or "infinitesimal" factor in the miner's total disability.

[20] If either party wishes to contest that fact, I will, upon request reconsider this issue. However the altitude is noted as: Elevation: 2,437. See: http://www.beckley.org/.

With respect to the use of blood gas studies and pulmonary function (ventilatory) studies, "the Board consistently has held that pulmonary function studies and blood gas studies are not diagnostic of the etiology of the respiratory impairment, but are diagnostic only of the severity of the impairment." ***Tucker v. Director, OWCP***, 10 B.L.R. 1-35, 1-41 (1987). As a result, the Board concluded that "a claimant who establishes the existence of total disability pursuant to subsections (c)(1) or (c)(2) of 20 C.F.R. § 718.204 with pulmonary function studies or blood gas studies . . ., has not also established that the total disability is due to pneumoconiosis." Id. at 1-41 and 1-42. The claimant must also establish, by a preponderance of the evidence, that the impairment evidenced by pulmonary function studies and blood gas studies was caused by pneumoconiosis.

As I noted above, the Employer's experts assert that if the Claimant has any respiratory deficit, the Claimant's disability is completely due to cigarette smoking (EX 8). The Claimant also has some cardiac involvement. In reviewing the medical opinion evidence regarding etiology, the opinions in of the physicians who failed to diagnose pneumoconiosis may be accorded little probative value. In ***Hobbs v. Clinchfield Coal Co.***, 45 F.3d 819 (4th Cir. 1995), the court held that the administrative law judge's finding that the miner's total disability was not due to pneumoconiosis was supported by substantial evidence as "[t]he medical opinions upon which he relied most strongly were not tainted by underlying conclusions of no pneumoconiosis pursuant to the broad legal definition contained in 20 C.F.R. § 718.201." On the other hand, in ***Toler v. Eastern Assoc. Coal Co.***, 43 F.3d 109 (4th Cir. 1995), the court held that, where the administrative law judge determines that a miner suffers from pneumoconiosis or is totally disabled or both, then a medical opinion wherein the miner is determined not to suffer from pneumoconiosis or is not totally disabled "can carry little weight" in assessing the etiology of the miner's total disability "unless the ALJ can and does identify specific and persuasive reasons for concluding that the doctor's judgment on the question of disability causation does not rest upon her disagreement with the ALJ's finding as to either or both of the predicates (pneumoconiosis and total disability) in the causal chain."

As I stated above, none of the Department of Labor or Employer experts accepted that the Claimant has proved that he has pneumoconiosis. Moreover, the Employer argues that even if he had pneumoconiosis, cigarette smoking trumps pneumoconiosis in this record. The Employer is correct that cigarette smoking may play a significant role in Claimant's respiratory problems. The Employer is also correct that the Claimant made several inconsistent statements concerning the extent of his smoking history.[21]

Again, I accept that the Claimant is a poor historian and is uneducated. I expect that there was some confusion and a reliance on unsupported facts incorporated into some of the reports rendered prior to the filling of the current application. However, Dr. Rasmussen's report of Mr. Evans' smoking history and estimate is more probative as it appears to be consistent with the hearing testimony, and is consistent with several other histories. (See DX 25 and CX 2, wherein Mr. Evans told several physicians, including Dr. Kabir, that he had smoked twenty five to thirty years.) Pneumoconiosis and coal dust exposure and cigarette smoking are not necessarily mutually exclusive under the law. The Sixth Circuit requires that total disability be "due at least in part" to pneumoconiosis. ***Adams v. Director, OWCP***, 886 F.2d 818, 825 (6th Cir. 1989); ***Zimmerman v. Director, OWCP***, 871 F.2d 564, 566 (6th Cir. 1989); ***Roberts v. Benefits Review Board***, 822 F.2d 636, 639 (6th Cir. 1987).[22] I accept that pneumoconiosis does not have to be the

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[21] I previously noted that he told one physician that he had never smoked cigarettes. Mr. Evans told another, Dr. Hudson, who diagnosed pneumoconiosis, that he had smoked thirty four (34) years (DX 33-5). However, Dr. Robinette reported fifteen (15) pack years and Dr. Rasmussen reported approximately twenty five (25) pack years. Dr. Fino had an opportunity to comment on the smoking history, but as he took the position, because so many of the test results were invalid, that there was no record of any respiratory deficit; it is reasonable that is why he did not comment further.

[22] The Seventh Circuit holds that pneumoconiosis must be a "*simple* contributing cause" of the miner's total disability (pneumoconiosis must be a necessary, but need not be a sufficient, cause of miner's total disability). ***Hawkins v. Director, OWCP***, 907 F.2d 697, 707 (7th Cir. 1990); ***Shelton v. Director, OWCP***, 899 F.2d 690, 693 (7th Cir. 1990). The Tenth Circuit requires that the pneumoconiosis be "at least *a contributing cause*." ***Mangus v. Director, OWCP***, 882 F.2d 1527, 1531 (10th Cir. 1989) (emphasis added).

sole cause.

Therefore, I must also discount the opinion of Dr. Branscomb, who did not have the recent treatment records before him, did not review the results of the February 2001 pulmonary function studies, x-ray, and Dr. Rasmussen's report, and because he inferred that tobacco and pneumoconiosis are mutually exclusive. And as to causation, Dr. Branscomb did not find that the Claimant has pneumoconiosis and therefore I do not accord the remainder of his argument any significant weight, ***Toler v. Eastern Assoc. Coal Co.***, *supra*.

Again, after a review of the entire record, I credit Dr. Rasmussen's opinion on causation, as he submitted the only report that considers the bulk of the current evidence. and is more rational than the report of Dr. Branscomb as to causation. The reports of Dr. Fino, Dr. Wiot and Dr. Perme are poorly documented and are not rational based on the current record. ***Fields v. Island Creek Coal Co.***,*supra* and ***Clark v. Karst-Robbins Coal Co.***, *supra*. I note that Dr. Rasmussen performed specific testing and to consider smoking as an exclusive source, that he considered the various possible sources, and that he accepts that smoking has an effect on the overall respiratory condition, but finds that pneumoconiosis is a "major contributing factor". I accept that this position is rational and that is reflects the law of the 6th Circuit. Again I note that both Dr. Branscomb and Dr. Fino never met the claimant and I accord significance to the fact that Dr. Rasmussen personally examined the Claimant. ***Cole v. East Kentucky Collieries***, 20 B.L.R. 1-51 (1996) (the administrative law judge acted within his discretion in according less weight to the opinions of the non-examining physicians; Moreover, none of the other physicians fully commented or even took into consideration Dr. Rasmussen's examination, and I accept the proposition found in Dr. Kabil's reports, that Mr. Evans has a progressive disease that has gotten progressively worse.

Therefore, I accept that the evidence shows that Mr. Evans has established that he has pneumoconiosis caused disability through the report of Dr. Rasmussen. 20 CFR 718.202(a)(4).

Onset of Total Disability

I have determined that the Claimant has proved that he is totally disabled as a result in major part from pneumoconiosis. Normally, benefits are payable from beginning with the month of onset of total disability.20 CFR 725.503 (b).

After a review of the time line in this case, I do not accept that the Claimant was totally disabled at the time that he filed this claim, April 17, 1999. By the time that he saw the Department of Labor physician, Dr. Seargeant, it is reasonable that the condition had becopme worse and that some of the symptoms of pneumoconiosis had progressed, but it was not until the Claimant was examined by Dr. Rasmussen in February , 2001, that the pneumoconiosis became apparent. The increase in symptomology is substantiated in part by the reports of Dr. Kabiil (CX 2) and by the testimony.

Therefore to a reasonable degree of probability, I find that the Claimant has been totally disabled as a result of pneumoconiosis since January, 2001, a reasonable time prior to the examination.

ORDER

IT IS ORDERED that the claim for benefits filed by Earl Evans is **granted.** The Employer, **Dixie Pine Coal Company** shall:

1. Pay to the Claimant, all benefits to which he is entitled, including augmented benefits to his dependent wife, Martha Hatfield Evans, and Thomas Christian Evans, dependent minor grandchild, under the Black Lung Benefits Act, commencing as of January 1, 2001, the month in which the Miner became entitled (33 U.S.C. §§ 906(a));
2. Claimant's attorney is granted thirty (30) days to submit an application for fees conforming to the requirements of 20 C.F.R. §§ 725.365 and §§ 725.366.

SO ORDERED.

A

Daniel F. Solomon
Administrative Law Judge

Notice of Appeal Rights: Pursuant to 20 C.F.R. §725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within 30 days from the date this decision if filed with the District Director, Office of Worker's Compensation Programs, by filing a notice of appeal with the Benefits Review Board, ATTN: Clerk of the Board, Post Office Box 37601, Washington, DC 20013-7601. See 20 C.F.R. §725.478 and §725.479. A copy of a notice of appeal must also be served on Donald S. Shire, Esquire, Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2605, 200 Constitution Avenue, NW, Washington, DC 20210.